TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
RICKY MCSHANE, DO

**Respondent Name**
INDEMNITY INSURANCE COMPANY OF NORTH AMERICA

**MFDR Tracking Number**
M4-17-0217-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
September 27, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The EOR/Denials state that the rendering/billing provider, Dr. Ricky McShane, is not on the 'Approved Doctor List.' . . . We have contacted the Texas Division of Workers Compensation and were told by a Healthcare Specialist that the 'Approved Doctor List' was discontinued in 2007."

**Amount in Dispute:** $240.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This claim is managed within the Coventry WC healthcare network. Requestor is not a doctor within the network. The carrier's denial of the bill was proper as the Requestor was not on the network's approved doctor list and was therefore not eligible to be paid for the billed services."

**Response Submitted by:** Downs Stanford, PC

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 19, 2016 and March 15, 2016 | Evaluation and Management Services 99213, Work Status Report 99080 | $220.00 | $220.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §126.8 establishes the division's former Approved Doctor List.
4. 28 Texas Administrative Code §133.3 sets out rules for communication between providers and insurance carriers.
5. 28 Texas Administrative Code §129.5 governs the filing of and payment for work status reports.
6. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
   - 811 – CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST.

**Issues**

1. Is this dispute eligible for medical fee dispute resolution?
2. Are the insurance carrier's denial reasons supported?
3. What is the recommended reimbursement for the disputed work status reports?
4. What is the recommended reimbursement for the disputed evaluation and management services?
5. Is the requestor entitled to additional reimbursement?

**Findings**

1. The respondent asserts that "This claim is managed within the Coventry WC healthcare network. Requestor is not a doctor within the network. The carrier's denial of the bill was proper as the Requestor was not on the network's approved doctor list and was therefore not eligible to be paid for the billed services."

   Review of records held by the division finds no notification to the division that the insurance carrier has enrolled the injured employee in a certified health care network (HCN) established in accordance with Insurance Code Chapter 1305. The respondent did not provide any documentation to support that the injured employee is enrolled in a certified HCN. The respondent does not state the name of the alleged network on the explanation of benefits or any of the submitted materials presented to the requestor prior to the filing of a medical fee dispute request.

   28 Texas Administrative Code §133.240(f)(15) requires that the paper form of an explanation of benefits shall include the "workers' compensation health care network name (if applicable)"

   Review of the submitted explanation of benefits (EOB) finds that the fields indicating "PPO Network" and "PPO Sub Network" are blank. No indication was found on the EOB that the injured employee is enrolled in a certified health care network (HCN) established in accordance with Insurance Code Chapter 1305. The insurance carrier has thus failed to meet the medical bill processing requirements of §133.240(f)(15).

   Moreover, the insurance carrier's EOB states: "Insurance carrier payment to the health care provider shall be according to Commission medical policies and fee guidelines in effect on the date(s) of service(s)." The insurance carrier failed to give to the doctor any plain language notice on the EOB that a network was involved.

   The insurance carrier further failed to give plain language notice of any rights or restrictions applicable under the alleged network rules. To the extent that the EOB fails to mention any network, network rules, medical policies or fee guidelines—and instead states that payment "shall be according to commission [now division] medical policies and fee guidelines"—the respondent has waived the right to assert a network or such rules and may not now raise the defense that any network medical policies or network fee guidelines should apply.

   Based on the information presented by the respondent for review, the division concludes the respondent has failed to support that the injured employee is enrolled in a certified HCN. Moreover, even were the injured employee enrolled in a network, the insurance carrier did not include the name of the alleged network on the EOB in accordance with the medical bill processing requirements of Rule §133.240(f)(15). The insurance carrier thus failed to give plain language notice to the provider that a network was involved or that any special requirements were applicable and has therefore waived the right to assert that network provisions apply.

   Labor Code §413.031(a)(1) states that a health care provider is entitled to a review of a medical service provided if a health care provider is "denied payment or paid a reduced amount for the medical service rendered."

   Labor Code §413.031(c) further states that "in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules."

   The Texas Workers' Compensation Act entitles health care providers to a review of medical services it they are denied payment. The Act further grants the division authority to resolve such disputes and adjudicate any payment. For these reasons, the division has jurisdiction to review the disputed medical fee issues.

2. The insurance carrier denied payment for the disputed services with claim adjustment reason codes:

   - 811 – CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST.
   - B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.

   The Commission [now the division] Approved Doctor List, as found in former 28 Texas Administrative Code §126.8, no longer exists; per Rule §126.8(c), that section was no longer effective on or after September 1, 2003.

   The respondent asserts "Requestor is not a doctor within the network. The carrier's denial of the bill was proper as the Requestor was not on the network's approved doctor list and was therefore not eligible to be paid for the billed services."

   The respondent did not submit a copy of the alleged approved doctor list—or documentation that the health care provider was not approved on the date of service—to support the insurance carrier's denial reasons. And, as stated above, the insurance carrier has waived the right to assert that network rules should apply.

   Moreover, 28 Texas Administrative Code §133.3(a) requires that:

   > Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

   The denial reason listed on the EOB refers to a list that is no longer maintained by the division and no longer a prerequisite for rendering treatment. The insurance carrier's denial reason does not mention a network or a network's list. The communication is therefore not of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill (or provide plain language notice of network involvement) and therefore does not meet the requirements of Rule §133.3(a) regarding communication between health care providers and insurance carriers.

   For the above reasons the division finds that the insurance carrier's denial reason code 811 – "CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST," is not supported.

   Furthermore, according to division consent order DWC-12-0089, dated May 30, 2012, this provider was removed as a *designated* doctor (and would not re-credential to apply to be on the designated doctor list). Additionally, he was deprived of the right to certify maximum medical improvement and/or assign impairment ratings in the workers' compensation system for a period of one year. That one year duration has since elapsed and the doctor may now certify maximum medical improvement and/or assign impairment ratings. Although this provider may not be designated by a treating doctor to perform required medical examinations or perform designated doctor duties, no such services are in dispute.

   As the services in dispute are not designated doctor services, the carrier's denial reason B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE" is not supported.

   Based on the preponderance of the information presented by the parties, the insurance carrier's denial reasons are not supported. The division finds the medical provider was not ineligible or disqualified from performing the disputed services on the dates of service. Accordingly, the disputed services will be reviewed for payment according to applicable division rules and fee guidelines.

3. This dispute regards, in part, payment for a work status report, billed under procedure code 99080, with reimbursement subject to the provisions of 28 Texas Administrative Code §129.5(i), which states that "The amount of reimbursement shall be $15." Documentation supports this report was billed twice, on January 19, 2016 and March 15, 2016 for a total reimbursement of $30.00. This amount is recommended.

4. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2016 is $56.82.

   For procedure code 99213, service dates January 19, 2016 and March 15, 2016, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.98843. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.006 is 1.01606. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.955 is 0.06685. The sum of 2.07134 is multiplied by the Division conversion factor of $56.82 for a MAR of $117.69. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $95.00. Documentation supports this evaluation was performed on two separate dates for a total reimbursement of $190.00. This amount is recommended.

5. The total allowable reimbursement for the services in dispute is $220.00. The insurance carrier has paid $0.00. The amount due to the requestor is $220.00.

**Conclusion**

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $220.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $220.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

| | Grayson Richardson | October 25, 2016 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.